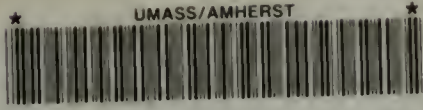


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UNIVERSITY

ALTERNATIVES TO
LONG-TERM INSTITUTIONAL CARE:

NEED

SERVICE PACKAGE

TARGETING

U OF MASS/AMHERST

Estimating the need for non-institutional long-term care services is difficult since need and demand figures are neither readily accessible nor precise. However, two factors have been identified from which a realistic need approximation can be generated.

The first factor is the number of alternative slots necessitated by the long-term care bed planning formula tentatively endorsed by the Health Policy Group. This formula yields a projection based on the institutionalized population who, if non-institutional care were not available and properly targeted to this population, would need institutional beds which are not allocated in the formula. Using this bed planning projection, there is a need for 6800 additional alternative slots. The bed planning formula implies a state policy commitment to community service for the elderly whenever possible. Also, since the formula anticipates the use of rest home/Community placement options rather than the building of institutional beds, it generates a need for such alternative services.

The bed planning formula has implications for the need which exists for expanded alternative care services. The restriction of institutional beds is not matched by the existence of the assumed alternative system. The development of that system is a precondition to restrictive bed planning. Therefore, restrictive bed planning must be tied to the development of the alternative care system.

There are several other factors which link bed planning to a need for alternatives development. Among them are:

- 1) The proportion of the elderly that has been institutionalized over the past twenty years has remained constant. This implies a very deeply rooted need for institutional services that can be changed only through the development of alternative services. A major re-orientation is necessary to change this institutional focus.
- 2) Given an excess of demand over supply for institutional services inherent in a very tight bed supply, nursing homes will give preference to the less disabled and private pay patients. We must find ways to counter this tendency, both through the development of institutional policies and the strengthening of the alternative system. If we do not, severely disabled and Medicaid patients, to whom the state should give first priority, will be unable to obtain placements and will either create backlogs in acute hospitals (for which Medicaid must pay) or will remain unidentified and unserved in the community.
- 3) The tight bed supply already undermines quality of care enforcement in nursing homes. As a result, DPW and DPH are forced to certify substandard facilities because there are no empty beds to which to transfer patients. Further tightening of the bed supply without

development of alternatives will create an intolerable situation in terms of quality regulation.

The second factor which delineates the need for alternative service is the percentage of the non-institutionalized elderly population with unmet needs who, if not served by an alternative care system, are at-risk of institutionalization. The Office of State Planning projects that in 1979 there will be 989,000 Massachusetts residents over the age of 60. Analyses performed by the National Center for Health Statistics, the Congressional Budget Office, and several studies done in Massachusetts by Laurence Branch and Floyd Fowler all suggest that there is an "unmet need" in the non-institutionalized elderly population at approximately a 5% level. That is, 5% of the non-institutionalized elderly population has an unmet need which can be serviced either through a mixture of alternative and support services or through institutionalization. Five percent of the projected 1979 elderly population yields a group with unmet needs numbering 49,450.

Need for Alternative Services

Necessitated by Long-Term Care
Bed Planning Formula

6,800

Five percent of the non-institutionalized
elderly population with "unmet need" and
so at-risk of institutionalization

49,450

56,250 individuals

For purposes of state provision of service, these numbers must be adjusted downward to reflect the proper income-eligible population percentage. Eighty percent of the current ICF population is Medicaid eligible. This percentage is likely to continue to apply, meaning that 5,440 of the 6,800 projected institutional elderly will be income-eligible. For the eligibility percentage of the non-institutionalized elderly population, we turn again to Branch and Fowler. Their findings suggest that 60% of the non-institutionalized elderly population will be income-eligible for service. This approximation would make 29,670 of the 49,450 individuals with unmet need service eligible.

Income-Eligible Population with Need for Alternative Care Services

Necessitated by Long-Term Care
Bed Planning Formula

5,440

Five percent of the non-institutionalized
elderly population with "unmet need" and
so at-risk of institutionalization

29,670

35,110 individuals

We thus arrive at a population of 35,110 which will need alternative services by 1980, to meet the needs of the at-risk non-institutionalized elderly and to provide the requisite alternative slots made necessary by the long-term care bed planning formula. Because services are to be targeted to the most disabled elderly, service recipients will need a "package" of services. For example, one individual might require homemaker and chore services, home health care, and adult day care. Thus, more than one "service unit", more than the receipt of a single type of service, will be necessary, on average, to maintain each individual in the community. It is estimated that each person will require between 2.0 and 2.5 "service units" to constitute his/her "alternative slot".

The alternative service package outlined in the next section, including Human Services, Elder Affairs, and Communities and Development components, represents the best efforts that the relevant state agencies can make in FY79 to develop the alternative service network. The package must be understood to be the most which can be done in an administratively effective manner in FY79.

What can be implemented efficiently in FY79 is significantly less than what is needed in the alternatives area based on both the bed planning formula and the unmet need in the general elderly population. Therefore, increased funding must be continued into FY80 and FY81. Without undue reliance on institutional care, the adequate provision of services to the elderly can only be accomplished through this increased alternatives commitment. If sufficient resources are not allocated to alternative services over the next several fiscal years, the state will be perpetuating a disparity between need in the elderly population and services available to this population.

The goal of increasing non-institutional long-term care services is the centerpiece of the plans of Health Systems Agencies. State agencies will work with regional Health Systems Agencies and Area Agencies on Aging to coordinate the implementation of these services on the community level.

A. Human ServicesHome Health Agencies - DPW/MA

There is a consensus that a set of capacity building activities should be developed by program personnel in DPH and DPW/MA which carry the likelihood of increasing home health agency capacity and efficiency. Home Health agencies will be encouraged to request funding, either by grant or for integration into their agency fee for service (rate) to upgrade their agency's capacity to deliver an expanded and better quality service. The Rate Setting Commission will approve those voluntary upgrading efforts which are deemed appropriate for integration into agency costs even if they cause the rate to exceed the 7% limitation. All such funding requests must be specifically approved by DPH and/or DPW/MA before the cost of the activity can be built into the rate or paid through the grant mechanism.

Appropriate for integration into an agency's rate on a prospective rate setting methodology are the following items:

1. Increasing staff capability to establish and strengthen liaisons with hospital discharge planning units, nursing homes, and community agencies.
2. Upgrading administrative and business management capacity in home health agencies.
3. Testing the provision of innovative services such as the utilization of nurse practitioners and psychiatric social workers.
4. Providing start-up money to encourage home health agencies to conduct clinics at public housing sites and other concentrations of elderly populations.
5. Allow funding for structural changes in home health agencies which will allow increased service provisions. For example, an overly centralized agency would be allowed to develop satellite offices to increase its capacity by reducing travel time.

Efforts should be made to limit agency's "fee for service" to the costs involved in the delivery of that service. Therefore, grant funds should be requested for the activities which involve more than one Home Health Agency and which benefit many such agencies. These activities may be short-term or one-time efforts and should not be reflected in the rate of any one agency.

A rapid rise in home health unit costs based on attempts at capacity building will be avoided by the generally conservative

Boards of Directors of home health agencies and by the general public. To the extent that resistance is spurred by feared unit cost increases, attempts to foster capacity-building will be thwarted. The grant mechanism would lessen the resistance to capacity-building for items which cut across agency lines.

Among these capacity-building areas for which grants should be made available:

1. advancing regionalization and encouraging the merger of small agencies.
2. subsidizing homemaker-home health aide training and recruitment programs, either through the agencies or on contract to third-parties.

We believe that a 25% total increase in home health billings to Medicaid can be realized during FY79 if the capacity-building package outlined above is operationalized and the new Conditions of Participation are implemented. By the end of FY79, capacity may be geared-up for an increase of more than 25%. That is, the annualized growth rate expected for FY80 may be higher than 25% because of the capacity-building accomplished in FY79. But this growth potential beyond the 25% level is largely conjectural for several reasons. There is no way to predict the number of Home Health Agencies which will opt to participate in the voluntary capacity-building activities. In addition, there is no way to assess before the fact how effective these activities and the Conditions of Participation will be in building Home Health Agency capacity.

One issue that does seem clear is that there is not a direct relationship between service increase and cost. Initial underutilization accompanies the inclusion of new services or activities, thereby raising unit costs. Therefore, to increase home health services 25%, a greater than 25% cost increase should be anticipated. These higher costs should level-off or drop as utilization of the new service or capacity-building activity is incorporated into the operations of the agency. There is strong sentiment that the costs of new capacity-building services or activities ought to be deemed allowable only if the proposing Home Health Agency, in applying to participate in voluntary upgrading activities, presents a plan which shows how the higher unit costs associated with start-up and initial underutilization will be controlled or lowered over time as the activity is fully phased-in. Costs will be allowed as long as projections relative to the ultimate effectiveness of the activity are made and adhered to.

A 25% service increase, assuming that such an increase will require a 40% increase in expenditure, translates to an increased FY79 service cost of \$3.1M. The total grant costs to be allowed in the rate, depending on how heavily utilized the activities are by the Home Health Agencies, should be in the area of \$750,000.

Total Cost: \$3.9M

--Adult Day Care - DPW/MA

We believe that 1000 additional Adult Day Care placements can be generated in FY79. The growth during FY78 will be from 100 to 400 placements. This program is growing quickly, but with careful control exercised over the quality of the programs accepted for participation. The strict medical assessment requirements guarantee that an appropriate at-risk population is identified and served.

Adult Day Care is an especially comprehensive alternative service which meets a wide range of medical and social needs of the participants. As such, it is an appropriate area in which to pursue expansion of the alternative system.

- 1000 additional Adult Day Care placements

Cost: \$2.1M (\$2125 average cost per placement x 1000 placements)

- Start-up costs for 30 ADC centers (600 placements) for programs which lack institutional or nursing home sponsors. There are sufficient sponsored programs available for 400 placements. Some or all of these start-up costs will be paid through DEA with Title III federal funds

Cost: \$240,000 (\$8000 average start-up cost x 30 ADC centers)

- Three program staff to monitor additional placements, publicize the programs, and provide technical assistance

\$50,000

Total Cost: \$2.4M

--Case Management - DPW/MA, DEA

During FY78, DPW/MA and DEA will implement the first pilot Case Management project in one Home Care Corporation area. The project will review elderly individuals at-risk of institutionalization and then target and package an appropriate alternative service mix to forestall institutionalization.

A core Case Management staff will be developed, along with a project staff in the pilot area. This staff will develop the project design, coordinate relationships with the community agencies and service providers in the pilot area, conduct client reviews, and perform out-reach into the non-institutionalized elderly population to identify individuals with unmet need.

In FY79, it is expected that 3 more Home Care Corporation areas can be selected for Case Management projects. The cost per project, assuming each serves 500 clients, is approximately \$100,000. This cost includes salaries of central office and field personnel, medical assessment costs, fringe benefits, and overhead. The increased FY79 cost,

reimbursable under Titles XIX and XX, will be approximately \$300,000.

DEA will set aside a portion of the social service budget in each pilot area for the targeted population reviewed by the Case Management project.

A Pre-Admission Screening project may be incorporated into the first Case Management pilot project area during FY79. Such a screening program would go beyond Case Management in that it would assess and channel all clients who enter the long-term care system, irrespective of the level of care they are deemed to require. Assessment by the Pre-Admission Screening mechanism would be a prerequisite for the receipt by an individual of Medicaid long-term care assistance. Case Management is more limited in scope than Pre-Admission Screening, since it concentrates on those individuals judged to be appropriate for home placement with the proper support services. Pre-Admission Screening, with the mandate to enforce level of care decisions, would meld with Case Management to provide a system which would properly place those individuals who require institutionalization while maximizing the number of individuals maintained at home.

This Pre-Admission Screening pilot, if it is found to be a program-matically sound approach during the implementation of the FY78 Case Management pilot, would cost approximately \$100,000. Most costs would be associated with assessment of individuals entering the long-term care system and effectuating the placement decisions made, since it is the appropriate channeling of individuals to various long-term care settings which is the key idea underlying Pre-Admission Screening.

Total Cost: \$400,000

B. Department of Elder Affairs

DEA intends to request \$30.6M in FY79 for its Home Care Corporation activities, up from \$22M to be expended in FY78. This budget request represents an assessment by DEA of the capacity of its system to efficiently utilize resources. Considering the pressing need for alternative services, the \$30.6M DEA request should be endorsed as the best response possible for the agency. In keeping with the commitment of the state to upgrade its alternative service network as quickly and effectively as possible, the full administratively feasible amount ought to be committed.

In addition to its regular Home Care Corporation request, there are three other areas in which DEA will work to extend its capacity and so better meet the alternative service need in the state.

1. The development of a Special Frail Elderly Program will be undertaken, centrally administered by DEA through the Home Care Corporations. There are assumed to be a number of elders in Massachusetts who are in danger of being institutionalized and who are not receiving the services necessary to prevent that institutionalization. This Special Frail Elderly Program, composed entirely of state funds, is needed because the Title XX link of all other home care service

money makes it impossible to deal with several issues which stand in the way of appropriate home care service to a group of at-risk individuals.

First, this special funding pool would allow for the provision of service to individuals whose income puts them slightly over the Title XX eligibility limit. A sliding fee scale will be used to allocate the cost burden appropriately.

Second, special targeting criteria can be added to services provided through this fund. It is difficult in a "semi-entitlement" program such as Title XX to target resources at a more selective population than the current client categories; differential targeting, such as for individuals over 75 and living alone, is of questionable validity within the context of Title XX regulations. In addition, the demand for home care services under Title XX is extremely high, and targeting specifically at high-cost, particularly at-risk individuals, while maximizing our goal of avoiding institutionalization, would restrict the number of individuals who could be served.

This Special Frail Elderly Program will increase the level of service which can be provided. It will allow for service provision to a population which is not now reached because of Title XX regulation. It provides for extremely well-targeted home care service, toward high need, at-risk individuals. Finally, it would serve as a demonstration project to evaluate potential changes for the current home care program.

Total Cost: \$2M

2. DEA will develop a Housing Pilot Project to deal with a wide range of housing needs among the elderly within the DEA service population. Home Care Corporations have identified inadequate housing as a major barrier to arranging home care services, and have said they do not have adequate staff to spend the time required to arrange for adequate housing for clients. In addition, there is insufficient knowledge among elders about available housing resources, and many of the programs are underutilized by elders because access is complicated. Finally, housing resources are often not properly coordinated with service resources.

The Housing Pilot Project would provide funds on a regional basis to establish or purchase housing information and advocacy services for elders within the context of home care services and to develop coordination of services with housing resources.

A statewide program could be implemented for the proposed budget amount if the following conditions are met:

- a. Centralized preparation and delivery of housing information,

advocacy information, and training for local staff. This could be done either with additional DEA staff, or by a subcontract to an already existing housing advocacy organization such as the Mass Law Reform Institute, Rural Housing Improvement, the Mass Union of Public Housing Tenants, etc.

- b. Regional organization of services that may encompass groups of Home Care Corporations rather than individual projects for each Home Care Corporation. This would not apply in all cases, but administrative savings would be possible in areas that have regionwide housing advocacy resources which could serve a consortium of Home Care Corporations.
- c. Utilization of Senior Aides, Elder Service Corps, CETA, or other resources to pay for housing advocacy staff. If arrangements cannot be made for this type of funding, it may be necessary to start the Housing Pilot Project in selected geographic areas rather than on an immediate statewide basis.

Total Cost: \$500,000

3. DEA will develop with DMH Crisis Counseling Services to serve elderly individuals in the community at-risk of institutionalization due primarily to an acute episode of psychological trauma. There are a number of crises ordinarily faced by elders which, if not resolved, can lead to rapid deterioration and the need for institutionalization. These crises can include loss of a spouse or close friend, onset of a chronic or acute condition that affects activities of daily living, or moving. Crisis Counseling is designed to provide immediate, intensive, and short-term mental health assessment, counseling, and support services to assist elders in negotiating the first days or weeks of a serious crisis. Once the crisis situation is over, the person can normally resume the same level of activity and self support as before the crisis, with a minimum of support and follow-up services.

DEA is in a unique position, through its Home Care Corporation structure, to identify individuals with this need and to target the appropriate crisis intervention service. Funds should be released on a selective basis to Home Care Corporations which can develop a workable program with local mental health resources. Perhaps a centralized DEA-DMH purchase arrangement would make it more likely that individual Home Care Corporations and area mental health agencies could form linkages through which this service could be provided.

There will be variation around the state in this program. Crisis

counseling resources are well-developed in some areas of the state and so can be easily tapped whereas in other areas, capacity must be built. The unit costs of crisis counseling services will therefore be uneven. Demand is difficult to assess, but with Home Care Corporation targeting, service provision ought to reflect real need.

Total Cost: \$1M (Contingent on purchase of service arrangements to be developed by EOHS)

C. Communities and Development

Housing is an integral part of any attempt to develop a coherent system of alternative care. The availability of appropriate housing and the provision of support services within the context of that housing is essential to the ability of the state to minimize institutionalization and maximize community maintenance.

The Department of Community Affairs can play an important role in the housing aspect of the alternative system. By developing and managing support mechanisms within its units, targeting its units to the frail elderly who can avoid institutionalization through the availability of public and supported housing, and increasing its efforts at subsidizing housing costs for elderly in the community, the Department can help make the alternative care system more effective.

Specifically, the Department can, with adequate FY79 funding and clear policy direction, undertake three initiatives which will impact positively on the general state strategy of developing the alternative system:

- 1) The Department will, on a pilot basis, work to develop a Service Coordination Capacity under the aegis of the local Housing Authorities (LHAs). For the LHAs with a sufficient population, a "service manager" to coordinate services for the frail elderly will be utilized. In smaller LHAs, the function can be contracted out to community agencies with interest and expertise in the area. This "service management" function is similar to that contemplated for the Case Management pilot project, but in a concentrated setting like an elderly housing development, the management capability is enhanced. Clients can be identified easily within the confines of the development and service packaging can be carried out efficiently.

Total Cost: \$150,000

- 2) The Department will Set-Aside 15-20% of all new CH667 units developed from the pending \$75M bonding authorization for congregate units or regular units earmarked for occupancy by the frail elderly, as jointly defined by DEA, DFW, and DCA. This set-aside will guarantee access, in a congregate

or otherwise supported setting, for over 500 elderly individuals who require a special supportive environment to avoid institutionalization.

3. Recognizing the pressure which elders face in maintaining themselves in their own apartments for financial reasons, the Department will request CH707 Rental Assistance Funding for an additional 150 subsidized units for the frail elderly, again as jointly defined by the relevant state agencies. This new allocation will avoid the dilemma of shifting rental assistance money from other needy categories of recipients (e.g. poor families) to needy frail elderly. The housing problem among the elderly is extremely significant and a major barrier to the provision of community-based services. This initial effort moves state policy in the direction of recognizing and meeting this need.

Total Cost: 3330,000 (150 units x \$2200 subsidy per unit)

All DCA service management and set-aside programs will be contingent on the availability of alternative care services to the relevant individuals. That is, DCA efforts will only proceed at a pace which can be accommodated by the remainder of the alternative care system.

ADDITIONAL FY79 COST AND SERVICE LEVELS

<u>Alternative Service</u>	<u>Total Cost</u>	<u>Funding Mechanism</u>	<u>State Cost</u>	<u>Service Units</u>
<u>HUMAN SERVICES</u>				
Home Health	\$3.9M	50% Medicaid reimbursement	\$1.9M	1250
Adult Day Care	2.4M	50% Medicaid reimbursement; Title III federal funding of start-up costs	1.0M	1000
Case Management	400,000	40% of project to receive 50% Medicaid reimbursement 60% of project to receive 40% Title XX reimbursement	225,000	1500
<u>ELDER AFFAIRS</u>				
Home Care Corp.	8.6M	Title XX reimbursement	4.3M	4725
Special Frail Elderly Program	2.0M	State funding	2.0M	1000
Housing Office Pilot Project	500,000	Title XX reimbursement	250,000	500
Crisis Counseling	1.0M	Title XX reimbursement Additional federal funding to be sought	500,000	500
<u>COMMUNITIES & DEVELOPMENT</u>				
Service Coordination Capacity	150,000	State funding	150,000	1000
Set-Aside Policy	---	----	----	500
CH707 Rental Assistance	330,000	State funding	330,000	150

TOTAL COST

\$19.3M

STATE COST

\$10.6M

FOOTNOTES

1. Not counted as service units because no new service is offered; other services are targeted; managed, and delivered. Same for proposed Communities and Development Service Coordination Capacity.
2. Title XX reimbursement is assumed to be at the 50% level because of the ceiling limitation.
3. Estimate assumes higher per client cost since the program will be targeted toward higher need individuals.
4. Estimate of population which can be reached and served in first year.
5. Contingent on acceptable purchase of service arrangement with DMH.
6. Total state cost \$15.7M if all Title XX increments are assumed to be 100% state funded because of the ceiling limitation.

TABLE II

15.

ADDITIONAL FY79 COST AND SERVICE LEVELS-
HUMAN SERVICES, ELDER AFFAIRS, AND COMMUNITIES
AND DEVELOPMENT

	<u>Total Cost</u>	<u>Total State Cost</u>	<u>Service Units</u>	<u>Alternative Slots</u>
Human Services	\$6.7M	\$3.1M	2250	1000
Elder Affairs	12.1M	7.0M	6725	2989
Communities and Development	480,000	480,000	650	289
TOTAL	\$19.3M	\$10.6M	9625	4278

TABLE III

EXTRAPOLATION OF HUMAN SERVICES, ELDER AFFAIRS, AND
COMMUNITIES AND DEVELOPMENT ALTERNATIVES
SERVICE GROWTH THROUGH FY81

NUMBER OF NEW SLOTS PER YEAR

THREE YEAR TOTAL

	<u>FY79</u>	<u>FY80</u>	<u>FY81</u>	
Human Services	1000	1000	1000	3000 ²
DEA ³	2989	3053	3170	9212
Communities and Development ⁴	289	289	289	867
Total	4278	4342	4459	13,079 ⁵

FOOTNOTES

1. Estimates 2.25 service units per alternative slot; the mid-point of the estimated range of 2.0 - 2.5 units per slot. This unit/slot assumption is used throughout. The resulting numbers represent the individuals estimated to be comprehensively served by an alternative slot in the community.
2. This total assumes additional expenditures in Human Services at the same level in FY80 and FY81 as proposed for FY79. That is, it presumes the creation of 1000 slots under the aegis of Human Service agencies in each of the 3 years.
3. DEA slot calculations are extracted and computed from the August 25, 1977 DEA projection of its proposed growth through 1984.
4. This total assumes additional expenditures in Human Services at the same level in FY80 and FY81 as proposed for FY79. That is, it presumes the creation of 289 slots under the aegis of EOCD in each of the 3 years.
5. The total of 13,079 slots is, over a 3 year period extending to 1981, the approximate number which is needed to meet the bed planning generated need alone by FY79, or, at the latest, FY80. The issue of unmet need in the elderly population as a whole, which certainly exists at some level even if the full 5% unmet need figure is questioned, is not significantly addressed by this level of effort. At best, 25% of the unmet need is treated after the bed planning need is met. The unmet need is thus not adequately addressed by the current projections of perceived administratively feasible additions to the alternatives system. If growth rates reflect the flat projections in Table III, many elderly will be unserved. The FY80 and FY81 projected growth rates need to be carefully examined to determine how much more capacity can be built and more service delivered. It is only in this way that restrictive bed planning and need in the elderly population can be adequately dealt with.

III. TARGETING

For the foreseeable future, the need for noninstitutional long-term care services will exceed the ability of the Commonwealth to provide them in an administratively feasible manner. Therefore, priority should be given to providing alternative care services to the "high risk" population that would be institutionalized in a nursing home or mental hospital without these services.

Given the Commonwealth's policy of strictly constraining the nursing home bed supply, especially for Intermediate Care Facilities, this triaging/targeting function is particularly important because of the tendency of nursing homes to prefer the less disabled and private pay patients. Without priority setting, the elderly most in need may find themselves "shut out" of the service delivery network.

For the short-term, we need to develop the alternatives system within the confines of the existing targeting mechanisms. A range of these mechanisms are in place or readily available. Over the longer term, more integrated targeting definitions and strategies can be developed.

A. Priority Populations

A basic targeting approach is to single out specific characteristics in a population which lead us to believe that individuals with those characteristics are at greater risk of institutionalization and so need to receive services. High priority should be given to providing additional alternative services to the following population groupings:

1. "Old" elderly (age 75 and over) and those without family supports (living alone, widows, widowers, or individuals who never married).

Approximately three-quarters of the nursing home population is age 75 or older. A similar proportion are widows, widowers, or were never married. These characteristics thus carry great predictive value as to an individual's proneness to institutionalization.

2. Elderly living in nursing home planning areas that are "underbedded".

The long term care bed planning formula can be used to identify geographic areas that have the most serious shortage of nursing home beds and, by implication, the greatest need for alternative care services. Areas with large numbers of Administratively Necessary Days (ANDs) should also receive priority attention and funding for alternatives since such a situation indicates a service need for long term care that is not being met.

3. Elderly with medical/psychiatric problems and functional impairments such that they would be institutionalized if alternative care services are not available.

This group includes those elderly with long term chronic impairments, including persons with ICF level disability. Many such individuals

could be maintained in the community given the appropriate support services. This population group also includes those elderly who have suffered an acute illness, usually requiring short-term hospitalization, whose recovery period may be lengthy. Such individuals are often institutionalized for recuperation and never return to the community. Many of these cases could be handled without the institutionalization period if alternative services were available and targeted.

B. Organizational Triaging Mechanisms

In addition to the establishment of population priorities, several formal, organizational mechanisms can be pursued to ensure proper targeting of services to the population most in need. Many of these methodologies are routinely utilized now, others could be tested quite readily, and another group (e.g. Case Management) are on a longer time-frame and will require some time to become effective targeting tools.

1. Intra-Service Targeting

Within each service category there are mechanisms which increase the likelihood that a given service will be delivered to a more at-risk population. Some of these devices are:

a. Medical Models

"Medical Models" are already utilized by Adult Day Care programs and Home Health Agencies to screen potential clients. Services are only provided to those who meet clinically determined medical criteria; proper targeting is assured by adherence to the clinical standards.

b. Capacity-Building

Capacity-building refers to the upgrading of existing service providers so that they can offer a quality and quantity of service capable of being a true alternative to nursing home care. Capacity-building also relates to increasing the capacity of an alternative service provider to select and serve a more at-risk population. DEA has already made the upgrading of the management and effectiveness of Home Care Corporations a high priority. Likewise, the new Conditions of Participation for Home Health Agencies to be promulgated by DPW and DPH will impose higher service provision standards on the Agencies. For example, Home Health Agencies will be required to have service available from 8 AM to 9 PM, to have the capacity to provide emergency 24 hours service to a client for up to 3 weeks, and to use "problem lists" in assessing clients to provide a more thorough, multi-dimensional statement of the client's condition and needs. The capacity-building activities proposed for Home Health Agencies in this service package contribute further to the development of agency service capacity.

c. Central Funding Pools

It has been suggested that centrally administered and targeted funds could be used to improve targeting. A central funding strategy increases the leverage of the agency in question to achieve specific objectives because only constituent organizations capable and willing to meet these objectives will receive funds. It provides better targeting because a formula distribution of funds does not allow for the rewarding of service providers who perform their targeting function very well. This targeting strategy is especially appropriate for DEA and DCA, but there might well be additional applicability.

d. Incentives

The development of incentives which provide specific targeting goals would provide a lever for state agencies to elicit better targeting from constituent organizations. The targeting goals could be set centrally, to reflect need in the at-risk population as defined by the state, and only when targeting is performed according to these standards will disposable resources be "earned". There could be no expenditures which missed the target populations because only in cases of documented adherence to clearly defined targeting goals would funds be allocated. Organizations would receive more money as they targeted toward the populations deemed most in need of service by the state. Such a monetary "incentive" would encourage proper targeting. The incentives could be built around outcomes as well, with organizations being rewarded for contributing to a lower than expected institutionalization rate in their service area. Financial penalties could be exacted if more institutionalization than predicted occurred. This system would motivate groups such as Home Care Corporations to target their limited resources to higher need, more at-risk individuals.

2. Inter-Service Linkages

The current non-institutional service system is highly fragmented. Improving linkages among services, especially health and social services, will improve the likelihood that the necessary service package can be coordinated. This coordination is a key to preventing unnecessary institutionalization and to limiting the need for more nursing home beds. Alternative services are of greater utility in avoiding institutionalization as they are better integrated with each other into a coherent package.

Acute hospitals are the primary source of nursing home placements. To tap this source and to reduce the incidence of institutionalization, it is essential to develop strong liaisons between hospital discharge planners and providers of noninstitutional service. DPH data indicates that acute hospitals with formal liaisons with Home Health Agencies, as proposed in the Conditions of Participation and urged by the capacity-building package for Home Health Agencies, have a higher utilization of home health services and a lower utilization of nursing homes as discharge destinations.

Mechanisms to improve the linkages between Home Care Corporations and acute hospitals should be explored. Also, Home Health Agencies and Home Care Corporations should be required to develop formal linkages among themselves to draw together the separate health and social service components alluded to above.

Attention ought to be given to inter-agency definitions of eligibility and client priority. Perhaps an inter-agency committee is appropriate to consider, in the short-term for FY79, how various agency targeting practices relate and can be unified. A long-term goal would be to develop uniform targeting guidelines across programs and agencies.

3. Case Management and Pre-Admission Screening

Case Management takes as its principal assumption that inappropriate utilization of nursing homes is best prevented by intervention prior to institutional placement. Thus, the Case Management program will review individuals and coordinate a package of noninstitutional services so that the greatest number of individuals who do not need nursing home level care can remain at home.

Pre-Admission Screening, which would assess all entrants to the long-term care system before Medicaid assistance is granted, would be a complement to Case Management in directing long-term care resources in the most appropriate manner and to the clientele most at-risk.

